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ABSTRACT

At any one time, between 2 percent and 17 percent of the school-age population in the United States experiences moderate to severe depression. Too often, depression goes unrecognized, damaging self-esteem, ruining academic achievement, and disrupting families. This paper discusses childhood depression and treatment. Following an introduction outlining the problem of childhood depression, the paper discusses the types, causes, and diagnosis of depression in school age children, and then details treatment types: electroconvulsive therapy, psychotherapy, and psychopharmacology. Next the paper discusses the development and education of the child's support system, particularly teachers and parents. The need for educators to recognize the signs of childhood depression and to realize the potential of depressed students, offer support, and accommodate their needs is considered. Finally, the paper recommends that schools should develop teacher education and awareness around depression, develop programs to provide counseling, and consult with parents concerning the child's needs. (JPB)

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Childhood Depression in School Age Children

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Abstract

At any one time, between 2% and 17% of the school age population in the United States experience moderate to severe depression. Often it goes unrecognized, damaging self-esteem, ruining academic careers, and disrupting families. Knowledge of the symptoms and what causes them are the first steps in identifying the depressed. The next step is to explore the treatment options, both in psychotherapy and psychopharmacology, and educate the child's support system to handle and help with those affected with the most successfully treated mental disorder, depression.

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Childhood Depression in School Age Children

To those who have had children with emotional problems, the frustration and helplessness a parent feels with what are at best difficult children are overwhelming. As parents, we struggle to raise our children using the tools we've been taught by our parents or those we have learned along the way, but even with reasoning, rewards, consequences and ignoring, the negative behaviors continue. Then, we consult therapists who suggest all you've tried and the frustration mounts. Then, a therapist recognizes the symptoms and with counseling and drug therapy the transformation begins. That is, until a teacher, whose rigidity and inability to comprehend the detriments of his philosophies, drives a child deeper into the depths of a depression that could lead to removal from school and possible institutionalization. A real need exists for educators to recognize the signs, realize potential, offer support, and accommodate, as much as possible, the needs of their special students. Along with teacher education and awareness, schools should develop programs to provide counseling and consult with parents concerning the child's needs.

INTRODUCTION

Depression is a debilitating disease that often goes unrecognized and untreated. Depression is highest among persons 25 to 44 years of age but recent research has proven that

children are far more affected than previously thought. "During a year's time, 8-9 percent of children between the ages of ten and thirteen suffer a major depression and a typical episode lasts for almost a year" (Ingersol & Goldstein, 1995, p. 22).

Some depression is normal and appropriate. Children who lose a loved one or suffer other losses, real or imagined, such as changing schools or friends moving, experience the blues, feeling low and depressed for a day or even weeks. This is not a clinical depression but merely a depressed mood. There is a point at which such responses become inappropriate and become a type of mental illness. Clinical depression has been called the common cold of mental illness. This may be true in its prevalence but not in its consequences. Colds do not bring those affected to the point of desperation exhibited by extreme sadness, worthlessness, and helplessness.

TYPES

Depression can take on many forms from minor to major, dysthymia to bipolar depressive disorder. Childhood depression is classified by 3 main types - acute, chronic, and masked. The chronic and acute are similar in characteristics for diagnosis but different in their "precipitating causes, the child's adjustment before the illness, the length of the illness, and the family history" (McKnew, Cytryn, & Yahraes, 1983, p.43). Chronic type has no apparent precipitating cause, it lasts longer than an

acute illness, and there's a history of previous depression, maternal depression, and marginal social and emotional adjustment. Acute type is normally in response to a traumatic event in the child's life or someone close to them. "In children with the type of disorder called masked depression, the sickness is often associated with so called acting-out behavior. This arises when a person tries to relieve or act out an emotional problem through antisocial acts that include stealing, setting fires, using drugs, running away, and beating people up" (McKnew, Cytryn, & Yahraes, 1983, p. 44). The challenge here involves diagnosing which is the primary and secondary problem and treating appropriately. The focus of this paper is on moderate, unipolar, clinical depression: realizing the causes, recognizing the symptoms, and restoring the mental health of the depressed child through professional, educational and family support.

CAUSES

There is no single cause for depression. Physiological factors, psychological factors, or a combination of both can trigger full blown clinical depression: yet, each can be sufficiently powerful in itself. Genetic theories top the list of suspects from the biological standpoint. There is no documented research that proves this, but the predisposition of depressed blood relatives of severely depressed persons is higher than that of the general population and identical twins have a much higher concordance rate than fraternal twins do (Erickson,

1987, p.280). Conditions such as hormone imbalances, nutritional neglect, and the intake of certain medications have been proven to precipitate depression. Recent research into the field of psychology has opened up a new area of suspicion. Neurotransmitter imbalances treated with drug therapies have proven to provide relief from depression. Theories also exist stating that a person's psychological patterns can affect the levels of these neurotransmitters (Papolos & Papolos, 1987, p. 81-84).

There are certain personality traits, childhood traumas, and feelings of low self-esteem and worthlessness that form the psychological basis for depression. Psychiatrists theorize that environmental influences and a child's perceptions of parental rejection often manifest themselves as depression caused by anger turned inward. Children have unique influences that negatively affect them. They deal with broken homes, divorce, desertion, increased violence, and sexual awareness at earlier ages. Coping skills are lacking at this point in their social and psychological development, and consequently, there are youth who need support systems and cannot find them. "There is mounting evidence that a constellation of harmful behaviors that accompany depression---suicide attempts, drug abuse, anorexia, bulimia and juvenile delinquency may be methods that young people use to cope with the anguish they feel" (Alper, 1986, p.2). Recognition of the symptoms and intervention in early stages can prevent these extreme consequences.

DIAGNOSIS

The symptoms of depression manifest themselves behaviorally, emotionally, psychologically, and physically. It involves changes not only in mood but in almost every area of a child's life as well. "Moodiness and emotional outbursts put a strain on relationships within the family, while friendships may suffer as the depressed youngster becomes increasingly withdrawn and isolated or aggressive and argumentative" (Ingersol & Goldstein, 1995, p.3). If an abrupt change in behavior occurs and the change lasts longer than 2 weeks or more, consultation with a counselor should be considered. In accordance with the DSM-IV Criteria for Major Depressive Disorder:

> At least five of the following symptoms must be present during the same 2-week period; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.
> - Depressed mood most of the day, nearly every day (either by subjective account; e.g., feels "down" or "low" or is observed by others to look sad or depressed)
> - Loss of interest or pleasure in all or almost all activities nearly everyday (either by subjective account or is observed by others to be apathetic)
> - Significant weight loss or gain (when not dieting or binge-eating)(e.g., > 5% of body weight in a month) or decrease or increase in appetite nearly every day (in children consider failure to make expected weight gains)
> - Insomnia or hypersomnia nearly everyday
> - Psychomotor agitation or retardation nearly everyday (observable by others, not merely subjective feelings of restlessness or being slowed down) (in children under 6, hypoactivity)
> - Fatigue or loss of energy nearly every day
> - Feelings of worthlessness or excessive or inappropriate guilt (either may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
> - Diminished ability to think or concentrate, or indecisiveness nearly every day (either by subjective account or observed by others)

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- Thoughts that he or she would be better off dead or suicidal ideation, nearly every day; or suicide attempt (Maag & Forness, 1991, p. 2)

Diagnosis of depression is not always quick and easy. Initially, the results of a careful history of symptoms and episodes, observation, physical exam, family history, and consultations with parents are examined. This is followed by the administration of standardized assessments measures that aid in attaining an accurate diagnosis. Three instruments that are particularly appropriate to and commonly used in clinical practice: the Children's Depression Inventory(CDI), the Children's Depression Scale(CDS), and the Depression Self-rating Scale(DSRS) (Shafii & Shafii, 1992, p.143). After the mental health professional evaluates the circumstances of the depression, a course of treatment is chosen.

TREATMENTS

Electroconvulsive

Common methods for the treatment of depression in children parallel those for adults encompassing a wide variety of techniques from different types of drug therapies to different forms of psychotherapy to electroconvulsive therapy(ECT). The most repulsive if not seemingly barbaric method of treating depression is ECT. One envisions "insane asylums" using this technique to control rather than to cure patients. The movie <u>One Flew Over The Cuckoo's Nest</u> did much to dissuade society from a

positive perspective. Today, in the field of psychiatry, doctors prescribe ECT as a safe and effective treatment (Papolos & Papolos, 1987, p. 115).

The patient receives a general anesthetic and a muscle relaxant. Electrodes are placed either on one temple or both and current is applied for .1 to .5 seconds and induces a "grand mal" seizure. An electroencephalograph measures the seizure which is over in about two minutes. From beginning to end, the procedure takes about 20 minutes. Patients receive treatments every few days until a course of 6 to 12 have been administered (Rush, 1983). This form of treatment is a last resort, reserved only for seriously depressed youngsters who do not respond to all other forms of treatment.

Psychotherapy

Psychotherapeutic alternatives include cognitive therapy, communication/relationship therapy, behavioral therapy, and insight-oriented therapy. Insight-oriented is based in large part on Freudian theories. The goal of this therapy is to uncover buried information from the unconscious and bring it into the child's conscious awareness. This is considered a "talk therapy." With children who have limited verbal skills, this transposes to "play therapy." The therapist uses toys, games, and play materials to establish a rapport, gain understanding and provide counseling on the child's level of cognitive functioning (Ingersol & Goldstein, 1995, p. 80-83) This type of therapy is

lengthly and expensive; shorter types of therapies are proving more practical in the treatment of childhood depression.

One such shorter approach is a cognitive therapy. The basis of this therapy supposes that depression is the result of cognitive distortions or maladaptive ways of thinking about themselves, the world, and the future. Low self-esteem, pessimistic outlook, and an overwhelming inability to cope all figure into this equation. This treatment is structured and time limited, usually 20 visits in 10-12 weeks. The theory suggests that negative assumptions develop during childhood. Cognitive therapy concentrates on changing this depressive thinking by "overcoming hopelessness, identifying problems, setting priorities, demonstrating the relationship between cognition and emotion and labeling errors in thinking" (Papolos & Papolos, 1987, p. 152). Therapists claim that this therapy can be used with children as young as ten but research has yet to prove its effectiveness on those under fourteen, "Recent attempts to combine elements of cognitive therapy with play therapy for use with younger children are intriguing, but research which supports this as a useful intervention with depressed children is not yet available" (Ingersol & Goldstein, 1995, p. 89).

Behavior therapy, also known as behavior modification, believes that behaviors are learned because they produce certain positive consequences or reinforcement. The therapist therefore sets up events so that desired behaviors are reinforced and undesirable behaviors can be diminished or eliminated by ensuring

they are never followed by positive consequences or by following them with negative consequences. This therapy also incorporates fear reduction techniques such as systematic desensitization. This combination has proven effective in the treatment of anxiety based problems, social withdrawal, temper tantrums and poor school performance. Behavior therapy alone is limited. More comprehensive treatment is attained when components of behavior therapy such as modeling, rehearsal, self-monitoring and rearranging consequences are combined with other therapies, especially cognitive therapy (Ingersol & Goldstein, 1995, p. 83-86).

The last area of psychotherapeutic approaches is the communication/relationship therapy to include family therapy and interpersonal therapy (IPT). IPT's main application is in the treatment of adolescents; family therapy, however, has the potential to benefit all family members. Therapists trained in this school view the child's problem as a reflection of disruption in normal family operation. Examples may include hidden marital problems, parental loss of authority or alliances of one parent and child against the other parent. In these cases, the child becomes the identified patient within a myriad of problems. Treatment includes teaching problem solving techniques, improving communication and helping parents reestablish their authority roles. In fixing the dysfunctional family, it is hoped that the depressed child will find relief. This is a brief, action-oriented approach that unfortunately

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"with the emphasis on the family as a whole the specific problems of the depressed child will be overlooked and therefore go untreated" (Ingersol & Goldstein, 1995, p. 91). Findings show that in moderate cases of clinical depression, psychotherapy may not be enough to relieve the symptoms. Treatment with drugs called antidepressants may be necessary.

Psychopharmacology

The advent of antidepressant drugs came about quite by accident. In 1956, American psychiatrist Nathan Kline administered Iproniazid to a patient with tuberculosis and discovered its mood elevating effects. In 1957, Swiss psychiatrist Ronald Kuhn administered imipramine and found it to be effective in treating depressive disorders (McKnew, Cytryn & Yahraes, 1983, p. 126). Once the link was confirmed between depression and medication, research into the physiology of the brain and its neurochemicals grew rapidly. After endless studies, it is now thought that depression is caused by a chemical imbalance in the brain. Three main chemicals known as neurotransmitters, serotonin, norepinephrine, and dopamine, transmit from one nerve cell to the next across a small junction or space called the synaptic gap or cleft. After the neurotransmitter is released into the gap, three things happen. Some are reabsorbed by the sending neuron; this is called reuptake. Some bind to receptors on the next neuron and some remain in the gap and naturally decompose. Scientists think that

the excessive reabsorption of neurotransmitters from the synapse creates a chemical imbalance that may lead to depressive disorder (McKnew, Cytryn & Yahraes, 1983, p. 124). So, the goal of antidepressant medication is to increase neurotransmitters in the synapse. The three major categories of antidepressant drugs are the selective serotonin reuptake inhibitors (SSRIs), tricyclics,, and monoamine oxidase inhibitors (MAOIs).

Monoamine Oxidase Inhibitors

MAOIs were one of the first two types of drugs prescribed for depression in the 1950s. These block the secretion of monoamine oxidase, an enzyme that aids in the natural degradation of serotonin, dopamine, and norepinephrine, thereby increasing the time and effect of the neurotransmitters. The two MAOIs currently available are Nordil and Parnate. A major drawback of the drugs that which makes it ill advised for children is that food rich in tyramine must be avoided. If taken with certain foods such as cheese, processed meats, beer and wine or other medications such as nasal decongestants or cough medicines, they could produce dangerously high blood pressure vomiting, headaches and chest pain. Even thought MAOIs are extremely effective with adults, the possible risks with children have led to little investigation in it's usefulness in children (Ingersol & Goldstein, 1995, p 103).

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Tricyclics

The second group prescribed in the 1950s were tricyclics. These block the reuptake of neurotransmitters thereby having the same effect as MAOIs. Some common tricycles available are Elavil, Sinequan, Tofranil(imipramine), and Pamelor. Almost immediately after the start of tricyclics, the patient notices an improvement in their ability to sleep restfully. Within two to three weeks, the individuals will find themselves more interested in life. Therapeutic levels have been established for some of the tricyclics, and blood tests are helpful in assuring the correct dosage and possibly avoiding some of the annoying side effects (Depaulo & Ablow, 1989, p. 142). "The results of several well-controlled studies support the clinical efficacy of imipramine in the treatment of prepubertal depression" (Campbell, Green & Deutsch, 1985, p 106). A note of caution on the discontinuance of tricyclics - "they should never be stopped abruptly; to do so can result in flu-like symptoms of nausea, stomach pain, vomiting and headaches" (Ingersol & Goldstein, 1995, p. 102).

Selective Serotonin Reuptake Inhibitors

The last group of antidepressants are the SSRIs. These drugs specifically block the reabsorption of serotonin again leaving more in the synaptic cleft. The first of these and the most celebrated in Prozac. First synthesized in 1972, it was approved for use in the United States in late 1987 (Cooper, 1994, p.129).

Since Prozac's introduction, Zoloft and Paxil have been added to the group of SSRIs. The discovery of Prozac was the first time a drug company deliberately set out to find a compound that would block serotonin reuptake. In the past, drugs prescribed for something else were accidentally found to treat depression. The goal of the researchers was to find a substance that gave the therapeutic results of the tricyclics but minimized the side effects that were attributed to the tricyclics' effect on norepinephrine (Cooper, 1994, p.731).

SSRIs are safer and less toxic than other antidepressants but as with any medication have side effects consisting of agitation, insomnia, and nausea. SSRIs are the drug of choice by most psychiatrists for adults. Not only have they been found to relieve depression but also anxiety, bulimia, and obsessive-compulsive disorders. "As for children, the results of early studies are promising. Preliminary findings are that this medication is both safe and effective for the treatment of mood disorders in children and adolescents" (Ingersol & Goldstein, 1995,p. 105).

Psychotherapy and antidepressants administered in unison have proven to be the most efficient, effective, and economical for patients. "Talk" and behavior therapies are beneficial however, it has yet to be conclusively determined that this method of treatment alone is the solution for different types of depression; nor can drugs alone bring about lasting change until resultant thinking and behaviors are explored and changed.

Like the chicken and the egg, it is often difficult to determine which came first the depression or the neurochemistry since one can precipitate the other.

Ablow, associate medical director at Tri-City Community Mental Health Centers in Lynn, MA, states it best when he says, "The next frontier in treating depression may be a re-realization that while these disorders could have roots in biochemistry and anatomy and genetics, some of the roots are in people's life stories. We need to pay attention to both" (Worsnop, 1992, p. 862). Along with psychotherapy and drug treatments, children must also have a support system in which they feel encouraged and secure.

SUPPORT SYSTEMS

Both at school and at home, those in authority must remember that all children want acceptance and approval. Children do not chose to suffer from depression any more than adults do or other children choose to suffer from a physical handicap. "Just as we cannot blame, argue, or punish such a child into walking or running, we cannot expect the depressed child to respond to logical arguments, anger, or punishment" (Ingersol & Goldsein, 1995, p. 147).

It is frightening to face the fact that the behavior you find so maddening is out of the child's control. While it is easier to hold on to the belief that the child could behave better if he or she tried hard enough, you are setting yourself up to feel

frustrated and angry. The result of this self defeating behavior on the adults part is to get locked into no-win power struggles where everyone loses. The teacher alienates the student and no learning is accomplished and the parent continues to live with an angry, withdrawn child who truly believes that life is hopeless and that no one loves them.

Parents

Parents shouldn't blame themselves and feel guilty. This doesn't do the child or the parent any good. As difficult as it might be to put your feelings aside, it is imperative for your child's mental health. Only after this is accomplished can you totally focus on the child's well-being and start acting in his or her best interest. Also, don't blame the child, whether or not he or she is at fault. Remember, this is a small human being with all the feelings and problems, even if at a different level or context, as an adult, and that it is not the child but the behavior that you "hate."

Next, and this is hard if you are angry, give the depressed child lots of special attention, praise, and emotional support. Personal involvement in the child's life by the parents makes the child feel important and worthy. "Generally speaking, the depressed child needs extra time to the parents alone" (McKnew, Cytryn & Yahraes, 1983, p. 148).

Finally, parents need to communicate with their children. The adult is responsible for initialing and keeping these lines open. Depressed children often will not or not know how to

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express how they are feeling. They will show it in irritability, changes in normal play behavior, eating habits, or sleep disturbances. If it is a loss that has caused the depression, encourage the child to grieve by talking about it. Let them talk openly about the loss, discuss their feelings, cry, and give them time. If it is your loss as well, show them your sadness and cry with them. Children experience grief differently then adults and as stated earlier, you must address it first. "After the grieving is done, help the child find a substitute person or thing to love," (McKnew, Cytryn, & Yahraes, 1983, p. 150).

If the depression is caused by stresses in the child's life, listening and encouraging are the best supports you can offer. Listening allows the child to share worries and concerns and put them in perspective. Talking helps you correct mistaken assumptions and give guidance. Encourage kids to exercise, become involved, make friends, have fun, and cry. Teach them to cooperate instead of confront, know their limits, care for themselves, express themselves assertively, how to relax, and how to identify stress so they can respond in healthier ways (Shamoo & Patros, 1990).

Parenting is a full time job, plus, and often there are not enough hours in the day to give the time and attention necessary for kids not to feel second best, left out, or unimportant. The quality of our interactions, however, can help our kids out of depression and help them develop into confident adults. These confident adults do not develop without the help of

educators who interact with our children 7-8 hours a day, 180 days a year.

Teachers

Teachers exert a powerful influence on our children. Youngsters spend more time in school then in most other structured settings outside the home, in their most consistent and extensive contact is with educators (Grob, Klein, & Eisen, 1983). It is critical that teachers be supportive for depressed children. Studies have shown that "between 2% and 17% of student attending general education school classes manifested moderate to severe levels of depressive symptomology" (Maag & Forness, 1991, p. 4). Alarmingly, studies have shown that although depressed children have a greater need for positive support, educators have a tendency to react more negatively to them. Lack of awareness and training in how to handle affected children contribute to these negative reactions. Peterson, Wonderlich, Reaven, and Mullins (1987) had teachers rate their feelings into response to four films in which a child was portrayed as either depressed or nondepressed and as having experienced either high or low life stress. The children who were both depressed and stressed received the most negative reactions from educators; the children who were either depressed or stressed were viewed less negatively; and the children who were neither depressed nor stressed received the most positive reactions. Depression clearly influenced educators responses in ways that could serve

to maintain a child's depression. Educators who communicate less positive and more negative behavior to a depressed child may enhance feelings of low self esteem, dysphoria, inadequacy, and helplessness. Because the well-being of the child is at stake and the risk of suicide increases with depression, teachers need to be particularly sensitive to this disorder and offer support to the student.

Teachers can help in a variety of ways. First, they should remember what it was like to be a child. Even for the most well-adjusted child, meeting the relentless demands of the school environment, where you have little or no say in what goes on, can be overwhelming. For the depressed child, it can be devastating. Remember how important it was to have the respect of your peers. The depressed child faces unavoidable humiliation on almost a daily basis. Their lives are filled with anxiety about who will sit with them on the bus, eat with them at lunch, or play with them at recess. If actively rejected, they will be taunted, teased, and sometimes assaulted. To depressed children, life is hopeless and they are helpless to do anything about it, and academic failure is soon to follow social failure.

If they remember the struggles of their childhood, perhaps educators can encourage more and judge less. Establish a rapport with the child, talk to them, and let them know they are important. Show this by giving them special jobs and responsibilities in which they can succeed. Praise them for even the smallest success and compliment them in front of their peers.

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Showing approval in front of their peers will do much for the child in terms of earning their respect. Having discussions with the class on what's expected in their social behavior in and out of class can influence the depressed child and their classmates. Praising publicly and correcting privately show by example how others should act. Other suggestion for helping include: plan classroom activities in which the depressed children can participate with other children as an equal or even a superior, make use of activities which involve cooperation not competition, and intervene actively to break up cliques (Ingersol & Goldstein, 1995, p.170-173). Most importantly, be positive and respect the parent's knowledge and understanding of the child. The teacher is the academic expert and the parent is the child expert. A blending of these will help in working with depressed children.

CONCLUSION

Childhood depression is debilitating and, if left untreated, is potentially a life-threatening condition. What was once referred to as "going through a phase", we now recognize as the symptoms of depression. "We know that the rate of depression is actually on the increase in this country and abroad" (Ingersol & Goldstein, 1995, p. 185). Nature and nurture both play a part in the explanation of the rising numbers. We can't do much about the nature factors but the nurture side can be manipulated to lessen the effects of poverty, victimization, family dysfunction, and increased societal expectations. Unfortunately, society does

not change easily and these problems will continue in one context or another. Fortunately, childhood depression is now a recognized problem and research is deepening our understanding and broadening the treatment options available. The triad of psychotherapy, psychopharmacology, and support systems from parents and teachers insure a brighter future for the affected youngsters. Awareness, education, and implementation for children and their caregivers will result in a happier, more productive society for tomorrow's generations.

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